

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10304

CERTIFICATE OF DEATH

10258

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Street</u> | | | | c. LENGTH OF STAY IN 1b <u>3 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rd. # 2 Box 107-A Old Forge Hill Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Akelaitis</u> Last <u>(Ackley)</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 24, 1878</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u> | | | 11b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Vincent Juodvirsiog</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lucia Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Peter F. Ackley, Rd. #2, Box 107A, Street, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic hypertensive cardio-vascular disease</u> DUE TO (c) <u>Chronic hypertensive cardio-vascular disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>59</u> , to <u>Sept. 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 9</u> , 19 <u>59</u> , and that death occurred at <u>1:25 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u> | | | | DATE SIGNED <u>September 10, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/12/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford County, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St</u> <u>BEL Air, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u> | |

CERTIFICATE OF DEATH

0304

| | | | | | |
|---|--|---|--|---|--|
| <p>1. NAME OF DECEASED [REDACTED]</p> | | <p>2. SEX [REDACTED]</p> | | <p>3. AGE [REDACTED]</p> | |
| <p>4. DATE OF BIRTH [REDACTED]</p> | | <p>5. PLACE OF BIRTH [REDACTED]</p> | | <p>6. OCCUPATION [REDACTED]</p> | |
| <p>7. MARITAL STATUS [REDACTED]</p> | | <p>8. CAUSE OF DEATH [REDACTED]</p> | | <p>9. MANNER OF DEATH [REDACTED]</p> | |
| <p>10. DATE OF DEATH [REDACTED]</p> | | <p>11. PLACE OF DEATH [REDACTED]</p> | | <p>12. SIGNATURE OF DECEASED [REDACTED]</p> | |
| <p>13. SIGNATURE OF WITNESS [REDACTED]</p> | | <p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p> | | <p>15. SIGNATURE OF CORONER [REDACTED]</p> | |
| <p>16. SIGNATURE OF JUDGE [REDACTED]</p> | | <p>17. SIGNATURE OF CLERK [REDACTED]</p> | | <p>18. SIGNATURE OF REGISTRAR [REDACTED]</p> | |

ATTEST: I, CLERK OF THE BOARD OF HEALTH, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE BOARD OF HEALTH, BALTIMORE, MARYLAND, THIS [REDACTED] DAY OF [REDACTED], 19[REDACTED].

CLERK OF THE BOARD OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10259

Reg. Dist. No.

10305

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Road</u> | | d. STREET ADDRESS <u>Harford Road</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Sommerfield Bachman</u> | | 4. DATE OF DEATH Month Day Year <u>September 13 1959</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 26 1949</u> |
| 9. AGE (In years last birthday) <u>10</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At School</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John S. Bachman Sr.</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Bertie B. Brandt</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>John S. Bachman Sr.</u> Address <u>Box 116 Harford Rd Joppa Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Punshot wounds cerebrum</u> 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot by friend with shot gun</u> |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>3:25</u> a.m. <u>9-13</u> p.m. <u>59</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | 20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>9-13-59</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Sept 16 59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemi</u> | 22d. LOCATION (City, town, or county) <u>Long Green Md.</u> (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald Bree</u> ADDRESS <u>7110 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. One Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10275

10260

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Aberdeen, Maryland | | | | d. STREET ADDRESS 681 Plater St. | | | |
| 3. NAME OF DECEASED (Type or print) First LAWRENCE Middle BAEKEY Last BAEKEY | | | | 4. DATE OF DEATH Month September Day 1 Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/3/1917 | |
| 9. AGE (In years last birthday) 41 | | 10. IF UNDER 1 YEAR Months 4 Days 4 | | 11. IF UNDER 24 HRS. Hours 4 Min. 4 | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Explosive Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Packing Company | | | |
| 11. BIRTHPLACE (State or foreign country) Harford County, Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME George H. Baekey | | | | 14. MOTHER'S MAIDEN NAME Nellie Boyd | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. Unknown | | | |
| 17. INFORMANT Mrs. Marie Baekey | | | | Address 681 Plater St., Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal hemorrhage DUE TO rupture of aneurysm of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 022x | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF 9/3/59 | | 22c. NAME OF CEMETERY OR CREMATORY Angel Hill | |
| 22d. LOCATION (City, town, or country) (State) Harford County, Md. | | | | 24a. REC'D BY REGISTRAR SEP 4 '59 | | | |
| 23. FUNERAL DIRECTOR Barrymore, Md. | | | | 24b. REGISTRAR'S SIGNATURE Carlton L. Hines | | | |

MEDICAL CERTIFICATION

2

2

DP

1

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF THE CENSUS

Wm. H. H. H.

Wm. H. H. H.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital | | d. STREET ADDRESS Cokesbury | |
| 3. NAME OF DECEASED (Type or print) Helen O. BANKS | | 4. DATE OF DEATH Sept 5 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 28, 1907 |
| 9. AGE (In years birth day) 52 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward L. Kell | |
| 14. MOTHER'S MAIDEN NAME Anna R. Brown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 219-10-9177 | | 17. INFORMANT Mrs William Rice, Havre De Grace, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Ovary 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 1959 , to Sept 5 1959 , that I last saw the deceased alive on Sept 5 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 9/5/59 | | | |
| ACTUAL SIGNATURE George T. Stansbury M.D. | | | |
| PHYSICIAN'S NAME (Type) George T. Stansbury | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | 9-8-1959 | Cokesbury Cemetery | Port Deposit, Md. Rural |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. L. Patterson ADDRESS Perryville, Md. | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| | | DATE SEP 9 '59 | Arthur E. Kline |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10262

10306

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> | | c. LENGTH OF STAY IN 1b <u>21 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital, Aberdeen Proving Ground, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>STOESSEL</u> Middle <u>SMYTHE</u> Last <u>BARKSDALE</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>24 Feb 1905</u> |
| 9. AGE (In years last birthday) yrs. <u>54</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier - Colonel</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Alabama</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>418-01-5806</u> | |
| 17. INFORMANT <u>Official Army Records</u> | | Address | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>21 days</u> <u>unknown</u> |
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|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|---|--|--|

| | | | |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | |
|---|--|
| 21. I certify that I attended the deceased from <u>1 Sept</u> , 19 <u>59</u> , to <u>21 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 Sept</u> , 19 <u>59</u> , and that death occurred at <u>1250 M.</u> from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Joseph A. Grossman</u> M.D. | ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hospital, Aberdeen Proving Ground Maryland</u> |
| PHYSICIAN'S NAME (Type) <u>JOSEPH A. GROSSMAN CAPT MC</u> | |

| | | | |
|---|-------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>9-25-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook - Blight Inc. 6009 Harford Rd. Balto.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 29 59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Huns</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10307

CERTIFICATE OF DEATH

Reg. Dist. No.

10263

| | | | | | | | |
|--|---|---|------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | | c. LENGTH OF STAY IN 1b - | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) US Army Hospital Aberdeen Proving Ground, Md | | | | d. STREET ADDRESS 129 A Hawthorne Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EVELYN BOYKIN | | | | 4. DATE OF DEATH Month Day Year September 2 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1959 September 1, 1959 | | 9. AGE (In years last birthday) yrs. Months Days Hours Min. 8 15 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Willie Lee Boykin | | | | 14. MOTHER'S MAIDEN NAME Dezzie Dee Staten | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) N/A | | 16. SOCIAL SECURITY NO. None | | INFORMANT Father Address 129 A Hawthorne Drive, Edgewood, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs 15 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sep 1, 19 59 , to Sep 2, 19 59 , that I last saw the deceased alive on Sep 2, 19 59 , and that death occurred at 3:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Alfred E Neuffer</i> M.D. | | | | DATE SIGNED 2 Sep 59 | | | |
| PHYSICIAN'S NAME (Type) ALFRED E NEUFFER CAPT MC | | | | USAH APG Md (Harford) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 8, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | 22d. LOCATION (City, town, or county) (State) Army Chemical Center, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. ...</i> | | | | ADDRESS <i>Aberdeen Md</i> | | 24a. REC'D BY REGISTRAR DATE SEP 10 '59 | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur L. ...</i> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050324XV1

STATE OF NEW YORK
IN SENATE
January 15, 1935
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 10, 1934
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1935

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10264

Reg. Dist. No.

| | | | |
|---|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun 07x-2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DDA Harford Memorial Hosp.</u> | | d. STREET ADDRESS <u>11 Mount St</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Sandra Kay Burchette</u> | | 4. DATE OF DEATH Month Day Year <u>September 12 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-19-43</u> |
| 9. AGE (In years last birthday) <u>16</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Rising Sun, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Vaughn Burchette</u> | | 14. MOTHER'S MARDEN NAME <u>Neva Grayson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Vaughn Burchette, Rising Sun, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull, compound</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - auto</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7-12</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 227 Conowingo Harford Md</u> | | 20f. (City or town) (County) (State) <u>Rising Sun Cecil Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>9-12-59</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/16/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Brookview</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Reed</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6277

17 OCT 1971

1971

DEATH

DEATH

NOISE

17 OCT 1971

1971

17 OCT 1971

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED <i>John Doe</i></p> | | <p>2. SEX <i>Male</i></p> | |
| <p>3. AGE <i>45</i></p> | | <p>4. DATE OF BIRTH <i>1910-10-15</i></p> | |
| <p>5. PLACE OF BIRTH <i>Baltimore, Maryland</i></p> | | <p>6. OCCUPATION <i>Teacher</i></p> | |
| <p>7. MARITAL STATUS <i>Married</i></p> | | <p>8. DATE OF MARRIAGE <i>1935-05-10</i></p> | |
| <p>9. NAME OF SPOUSE <i>Jane Doe</i></p> | | <p>10. DATE OF DEATH <i>1955-03-20</i></p> | |
| <p>11. PLACE OF DEATH <i>Home</i></p> | | <p>12. CAUSE OF DEATH <i>Heart Disease</i></p> | |
| <p>13. MEDICAL HISTORY <i>None</i></p> | | <p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p> | |
| <p>15. SIGNATURE OF REGISTRAR <i>[Signature]</i></p> | | <p>16. OFFICIAL SEAL <i>[Seal]</i></p> | |

UNIVERSITY OF MARYLAND
Baltimore, Maryland
This is to certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health.

10279

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARTFORD</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u> | | | c. LENGTH OF STAY IN 1b <u>34 years</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bel Air Road</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Oliver</u> Last <u>Davis</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 23 - 1891</u> | | 9. AGE (In years last birthday) <u>67</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tourist Camp</u> | | 11. BIRTHPLACE (State or foreign country) <u>Long Green Md</u> | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> |
| 13. FATHER'S NAME <u>Jefferson Davis</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Stewart</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>264-50-0013</u> | | 17. INFORMANT <u>MRS Amos O Davis</u> Address <u>Bel Air Md RD 3 Box 60</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>59</u> , to <u>Sept 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P. M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Charles Richardson</u> M.D. | | | ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>9/6/59</u> | | |
| PHYSICIAN'S NAME (Type) <u>Charles Richardson, Jr. M.D.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>Sept 8/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Fountain Green, Hartford, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md</u> | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10280

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace | | c. LENGTH OF STAY IN 1b X Aberdeen (Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital | | d. STREET ADDRESS R.D. #2 | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle MOSES Last DEAN | | 4. DATE OF DEATH Month September Day 14 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 Feb. 1879 |
| 9. AGE (In years last birthday) yrs. 80 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Noah Dean | | 14. MOTHER'S MAIDEN NAME Mary Freeman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. *** ** | |
| 17. INFORMANT Robert L. Dean | | Address RD. #2, Aberdeen, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 72 hr. 72 hr. 1 yr. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1953 , 19____, to 9-14- , 19 59 , that I last saw the deceased alive on 9-14- , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Peter P. Rodman M.D. | | ADDRESS (Street, city or town, State) 8, Law St - Aberdeen, Md. | |
| DATE SIGNED 9/15/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/17/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 22d. LOCATION (City, town, or county) (State) R.D., Bel Air, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring | | 24. REC'D BY REGISTRAR SEP 21 59 | |
| 24b. REGISTRAR'S SIGNATURE Robert L. Dean | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

Page Two

DATE OF DEATH

1920

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

EDUCATION

COLOUR

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

NAME OF FATHER

NAME OF MOTHER

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

PRE-EXISTING INJURY

PRE-EXISTING WEAKNESS

PRE-EXISTING DEFECT

PRE-EXISTING DISORDER

PRE-EXISTING ABNORMALITY

PRE-EXISTING LESION

PRE-EXISTING PATHOLOGY

PRE-EXISTING SYMPTOM

PRE-EXISTING SIGN

PRE-EXISTING FINDING

PRE-EXISTING RESULT

PRE-EXISTING EFFECT

PRE-EXISTING ACTION

PRE-EXISTING REACTION

CERTIFICATE OF DEATH

10269

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CLAYS D FREEBURGER | | 4. DATE OF DEATH September 8 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/31/01 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE CHAPMAN | | 14. MOTHER'S MAIDEN NAME Bessie Wahl | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Walter B. Freeburger, Edgewood, Maryland. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) approx 5 hrs. (c) approx 5 hrs. | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 6th, 1959 to Sept 8th, 1959 , that I last saw the deceased alive on Sept 8th, 1959 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edward C. Loo, M.D. | | ADDRESS (Street, city or town, state) 211 N. Union Ave. | |
| PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. | | DATE SIGNED 9/9/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 12, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial | | 22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Thomas | | ADDRESS Abingdon, Md., | |
| 24a. REC'D BY REGISTRAR SEP 14 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10270

Reg. Dist. No.

10283

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> | | c. LENGTH OF STAY IN 1b <i>Lifetime</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>118 St. John St.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Hannah</i> First <i>Halloway</i> Middle Last | | 4. DATE OF DEATH Month <i>Sept.</i> Day <i>18</i> Year <i>1959</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 12, 1882</i> |
| 9. AGE (In years last birthday) <i>77</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Harre de Grace, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Alfred Durbin</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Martin</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT <i>Mr. Joseph Durbin - Harre de Grace, Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Heart disease</i> DUE TO (c) <i>Arteriosclerotic Heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sept. 8</i> , 19 <i>59</i> , to <i>Sept. 17</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept. 17</i> , 19 <i>59</i> , and that death occurred at <i>2:00 A.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>George T. Stansbury</i> | | ADDRESS (Street, city or town, state) <i>569 Revolution St. Harre de Grace, Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i> | | DATE SIGNED <i>9/19/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Sept. 21, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cm.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Bullock</i> | | ADDRESS <i>Harre de Grace, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>SEP 22 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur A. Hanes</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1915</u></p> | | <p>4. Place of birth: <u>NEW YORK</u></p> | |
| <p>5. Date of death: <u>1965</u></p> | | <p>6. Place of death: <u>NEW YORK</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Manner of death: <u>Natural</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of registration: <u>1965</u></p> | | <p>12. Place of registration: <u>NEW YORK</u></p> | |
| <p>13. Name of informant: <u>[Name]</u></p> | | <p>14. Address of informant: <u>[Address]</u></p> | |
| <p>15. Date of completion: <u>1965</u></p> | | <p>16. Place of completion: <u>NEW YORK</u></p> | |

10284

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Hartford</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartford-Grace</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hartford Memorial Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Warren Gardner Garey</i> | | | | 4. DATE OF DEATH Month Day Year <i>9 13 1959</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>Jan. 16, 1911</i> | 9. AGE (In years last birthday) <i>48</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chef</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John W. Garey</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Alice Buchanan</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>383-01-5598</i> | | 17. INFORMANT <i>Thomas B Garey</i> Address <i>313 Hopkins Rd</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Passive Congestive HF</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocarditis</i> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 mos</i> <i>2 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral Pneumonia - Chronic Pericarditis</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Sept 7, 1959</i> , to <i>Sept 13, 1959</i> , that I last saw the deceased alive on <i>Sept 13, 1959</i> , and that death occurred at <i>3⁴⁰ P. M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Ralph Horky</i> | | | | DATE SIGNED <i>Sept 14</i> | | | |
| PHYSICIAN'S NAME (Type) <i>J. Ralph Horky MD</i> | | | | M.D. <i>Churchwell</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9/16/59</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Tarring</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>SEP 21 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10285

CERTIFICATE OF DEATH

Reg. Dist. No.

10272

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u> | | | | c. LENGTH OF STAY IN 1b <u>17 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Steve</u> Middle <u>GLAROS</u> Last <u>GLAROS</u> | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 20, 1907</u> | |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Alexander, Egypt</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Egypt</u> ✓ | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>097-09-0711</u> | | 17. INFORMANT <u>Pete Mavrelis</u> | | Address <u>306 S. Phila. Blvd. Aberdeen, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> <u>543X</u> DUE TO <u>Acute Phlegmonous Gastritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cinbrosis of the Liver</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/16</u> , 19 <u>59</u> , to <u>9/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>59</u> , and that death occurred at <u>11:50</u> M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W.H. Sadowsky</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>504 LEWIS ST Harford, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W.H. SADOWSKY</u> | | | | DATE SIGNED <u>9/17/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/20/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Tanning</u> ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>SEP 22 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carlton B. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10588

Rev. 04-1-12

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED [REDACTED]</p> | | <p>2. SEX [REDACTED]</p> | |
| <p>3. AGE [REDACTED]</p> | | <p>4. DATE OF BIRTH [REDACTED]</p> | |
| <p>5. PLACE OF BIRTH [REDACTED]</p> | | <p>6. OCCUPATION [REDACTED]</p> | |
| <p>7. MARITAL STATUS [REDACTED]</p> | | <p>8. CAUSE OF DEATH [REDACTED]</p> | |
| <p>9. MEDICAL HISTORY [REDACTED]</p> | | <p>10. DATE OF DEATH [REDACTED]</p> | |
| <p>11. PLACE OF DEATH [REDACTED]</p> | | <p>12. SIGNATURE OF DECEASED [REDACTED]</p> | |
| <p>13. SIGNATURE OF WITNESS [REDACTED]</p> | | <p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p> | |
| <p>15. SIGNATURE OF CLERK [REDACTED]</p> | | <p>16. SIGNATURE OF REGISTRAR [REDACTED]</p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

10308

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------------|--|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodley Farm</u> | | | | d. STREET ADDRESS <u>Woodley Farm</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rora</u> Middle <u>Tasco</u> Last <u>Harri's</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>16th</u> Year <u>1919</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 2, 1878</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Samuel E. Tasco</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>Mary A. Hollingsworth</u> Address <u>Box 56 Perryman</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive - Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertensive - Arteriosclerotic Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>59</u> , to <u>9/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>George J. Stansbury</u> | | | | ADDRESS (Street, city or town, state) <u>569 Revolution St. Harford, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | | | DATE SIGNED <u>9/18/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/19/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Loreley, Balto. County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Harring - Aberdeen Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>SEP 22 1959</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------------|--|----------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | |
| 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. SIGNATURE OF PHYSICIAN | |
| 10. SIGNATURE OF REGISTRAR | | 11. SIGNATURE OF WITNESSES | | 12. SIGNATURE OF CORONER | |
| 13. SIGNATURE OF JUDGE | | 14. SIGNATURE OF CLERK | | 15. SIGNATURE OF SHERIFF | |
| 16. SIGNATURE OF DEPUTY SHERIFF | | 17. SIGNATURE OF CONSTABLE | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF GRAND JURY | | 20. SIGNATURE OF COURT | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF SHERIFF | | 24. SIGNATURE OF DEPUTY SHERIFF | |
| 25. SIGNATURE OF CONSTABLE | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF GRAND JURY | |
| 28. SIGNATURE OF COURT | | 29. SIGNATURE OF JUDGE | | 30. SIGNATURE OF CLERK | |
| 31. SIGNATURE OF SHERIFF | | 32. SIGNATURE OF DEPUTY SHERIFF | | 33. SIGNATURE OF CONSTABLE | |
| 34. SIGNATURE OF JURY | | 35. SIGNATURE OF GRAND JURY | | 36. SIGNATURE OF COURT | |
| 37. SIGNATURE OF JUDGE | | 38. SIGNATURE OF CLERK | | 39. SIGNATURE OF SHERIFF | |
| 40. SIGNATURE OF DEPUTY SHERIFF | | 41. SIGNATURE OF CONSTABLE | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF GRAND JURY | | 44. SIGNATURE OF COURT | | 45. SIGNATURE OF JUDGE | |
| 46. SIGNATURE OF CLERK | | 47. SIGNATURE OF SHERIFF | | 48. SIGNATURE OF DEPUTY SHERIFF | |
| 49. SIGNATURE OF CONSTABLE | | 50. SIGNATURE OF JURY | | 51. SIGNATURE OF GRAND JURY | |
| 52. SIGNATURE OF COURT | | 53. SIGNATURE OF JUDGE | | 54. SIGNATURE OF CLERK | |
| 55. SIGNATURE OF SHERIFF | | 56. SIGNATURE OF DEPUTY SHERIFF | | 57. SIGNATURE OF CONSTABLE | |
| 58. SIGNATURE OF JURY | | 59. SIGNATURE OF GRAND JURY | | 60. SIGNATURE OF COURT | |
| 61. SIGNATURE OF JUDGE | | 62. SIGNATURE OF CLERK | | 63. SIGNATURE OF SHERIFF | |
| 64. SIGNATURE OF DEPUTY SHERIFF | | 65. SIGNATURE OF CONSTABLE | | 66. SIGNATURE OF JURY | |
| 67. SIGNATURE OF GRAND JURY | | 68. SIGNATURE OF COURT | | 69. SIGNATURE OF JUDGE | |
| 70. SIGNATURE OF CLERK | | 71. SIGNATURE OF SHERIFF | | 72. SIGNATURE OF DEPUTY SHERIFF | |
| 73. SIGNATURE OF CONSTABLE | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF GRAND JURY | |
| 76. SIGNATURE OF COURT | | 77. SIGNATURE OF JUDGE | | 78. SIGNATURE OF CLERK | |
| 79. SIGNATURE OF SHERIFF | | 80. SIGNATURE OF DEPUTY SHERIFF | | 81. SIGNATURE OF CONSTABLE | |
| 82. SIGNATURE OF JURY | | 83. SIGNATURE OF GRAND JURY | | 84. SIGNATURE OF COURT | |
| 85. SIGNATURE OF JUDGE | | 86. SIGNATURE OF CLERK | | 87. SIGNATURE OF SHERIFF | |
| 88. SIGNATURE OF DEPUTY SHERIFF | | 89. SIGNATURE OF CONSTABLE | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF GRAND JURY | | 92. SIGNATURE OF COURT | | 93. SIGNATURE OF JUDGE | |
| 94. SIGNATURE OF CLERK | | 95. SIGNATURE OF SHERIFF | | 96. SIGNATURE OF DEPUTY SHERIFF | |
| 97. SIGNATURE OF CONSTABLE | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF GRAND JURY | |
| 100. SIGNATURE OF COURT | | 101. SIGNATURE OF JUDGE | | 102. SIGNATURE OF CLERK | |
| 103. SIGNATURE OF SHERIFF | | 104. SIGNATURE OF DEPUTY SHERIFF | | 105. SIGNATURE OF CONSTABLE | |
| 106. SIGNATURE OF JURY | | 107. SIGNATURE OF GRAND JURY | | 108. SIGNATURE OF COURT | |
| 109. SIGNATURE OF JUDGE | | 110. SIGNATURE OF CLERK | | 111. SIGNATURE OF SHERIFF | |
| 112. SIGNATURE OF DEPUTY SHERIFF | | 113. SIGNATURE OF CONSTABLE | | 114. SIGNATURE OF JURY | |
| 115. SIGNATURE OF GRAND JURY | | 116. SIGNATURE OF COURT | | 117. SIGNATURE OF JUDGE | |
| 118. SIGNATURE OF CLERK | | 119. SIGNATURE OF SHERIFF | | 120. SIGNATURE OF DEPUTY SHERIFF | |
| 121. SIGNATURE OF CONSTABLE | | 122. SIGNATURE OF JURY | | 123. SIGNATURE OF GRAND JURY | |
| 124. SIGNATURE OF COURT | | 125. SIGNATURE OF JUDGE | | 126. SIGNATURE OF CLERK | |
| 127. SIGNATURE OF SHERIFF | | 128. SIGNATURE OF DEPUTY SHERIFF | | 129. SIGNATURE OF CONSTABLE | |
| 130. SIGNATURE OF JURY | | 131. SIGNATURE OF GRAND JURY | | 132. SIGNATURE OF COURT | |
| 133. SIGNATURE OF JUDGE | | 134. SIGNATURE OF CLERK | | 135. SIGNATURE OF SHERIFF | |
| 136. SIGNATURE OF DEPUTY SHERIFF | | 137. SIGNATURE OF CONSTABLE | | 138. SIGNATURE OF JURY | |
| 139. SIGNATURE OF GRAND JURY | | 140. SIGNATURE OF COURT | | 141. SIGNATURE OF JUDGE | |
| 142. SIGNATURE OF CLERK | | 143. SIGNATURE OF SHERIFF | | 144. SIGNATURE OF DEPUTY SHERIFF | |
| 145. SIGNATURE OF CONSTABLE | | 146. SIGNATURE OF JURY | | 147. SIGNATURE OF GRAND JURY | |
| 148. SIGNATURE OF COURT | | 149. SIGNATURE OF JUDGE | | 150. SIGNATURE OF CLERK | |
| 151. SIGNATURE OF SHERIFF | | 152. SIGNATURE OF DEPUTY SHERIFF | | 153. SIGNATURE OF CONSTABLE | |
| 154. SIGNATURE OF JURY | | 155. SIGNATURE OF GRAND JURY | | 156. SIGNATURE OF COURT | |
| 157. SIGNATURE OF JUDGE | | 158. SIGNATURE OF CLERK | | 159. SIGNATURE OF SHERIFF | |
| 160. SIGNATURE OF DEPUTY SHERIFF | | 161. SIGNATURE OF CONSTABLE | | 162. SIGNATURE OF JURY | |
| 163. SIGNATURE OF GRAND JURY | | 164. SIGNATURE OF COURT | | 165. SIGNATURE OF JUDGE | |
| 166. SIGNATURE OF CLERK | | 167. SIGNATURE OF SHERIFF | | 168. SIGNATURE OF DEPUTY SHERIFF | |
| 169. SIGNATURE OF CONSTABLE | | 170. SIGNATURE OF JURY | | 171. SIGNATURE OF GRAND JURY | |
| 172. SIGNATURE OF COURT | | 173. SIGNATURE OF JUDGE | | 174. SIGNATURE OF CLERK | |
| 175. SIGNATURE OF SHERIFF | | 176. SIGNATURE OF DEPUTY SHERIFF | | 177. SIGNATURE OF CONSTABLE | |
| 178. SIGNATURE OF JURY | | 179. SIGNATURE OF GRAND JURY | | 180. SIGNATURE OF COURT | |
| 181. SIGNATURE OF JUDGE | | 182. SIGNATURE OF CLERK | | 183. SIGNATURE OF SHERIFF | |
| 184. SIGNATURE OF DEPUTY SHERIFF | | 185. SIGNATURE OF CONSTABLE | | 186. SIGNATURE OF JURY | |
| 187. SIGNATURE OF GRAND JURY | | 188. SIGNATURE OF COURT | | 189. SIGNATURE OF JUDGE | |
| 190. SIGNATURE OF CLERK | | 191. SIGNATURE OF SHERIFF | | 192. SIGNATURE OF DEPUTY SHERIFF | |
| 193. SIGNATURE OF CONSTABLE | | 194. SIGNATURE OF JURY | | 195. SIGNATURE OF GRAND JURY | |
| 196. SIGNATURE OF COURT | | 197. SIGNATURE OF JUDGE | | 198. SIGNATURE OF CLERK | |
| 199. SIGNATURE OF SHERIFF | | 200. SIGNATURE OF DEPUTY SHERIFF | | 201. SIGNATURE OF CONSTABLE | |
| 202. SIGNATURE OF JURY | | 203. SIGNATURE OF GRAND JURY | | 204. SIGNATURE OF COURT | |
| 205. SIGNATURE OF JUDGE | | 206. SIGNATURE OF CLERK | | 207. SIGNATURE OF SHERIFF | |
| 208. SIGNATURE OF DEPUTY SHERIFF | | 209. SIGNATURE OF CONSTABLE | | 210. SIGNATURE OF JURY | |
| 211. SIGNATURE OF GRAND JURY | | 212. SIGNATURE OF COURT | | 213. SIGNATURE OF JUDGE | |
| 214. SIGNATURE OF CLERK | | 215. SIGNATURE OF SHERIFF | | 216. SIGNATURE OF DEPUTY SHERIFF | |
| 217. SIGNATURE OF CONSTABLE | | 218. SIGNATURE OF JURY | | 219. SIGNATURE OF GRAND JURY | |
| 220. SIGNATURE OF COURT | | 221. SIGNATURE OF JUDGE | | 222. SIGNATURE OF CLERK | |
| 223. SIGNATURE OF SHERIFF | | 224. SIGNATURE OF DEPUTY SHERIFF | | 225. SIGNATURE OF CONSTABLE | |
| 226. SIGNATURE OF JURY | | 227. SIGNATURE OF GRAND JURY | | 228. SIGNATURE OF COURT | |
| 229. SIGNATURE OF JUDGE | | 230. SIGNATURE OF CLERK | | 231. SIGNATURE OF SHERIFF | |
| 232. SIGNATURE OF DEPUTY SHERIFF | | 233. SIGNATURE OF CONSTABLE | | 234. SIGNATURE OF JURY | |
| 235. SIGNATURE OF GRAND JURY | | 236. SIGNATURE OF COURT | | 237. SIGNATURE OF JUDGE | |
| 238. SIGNATURE OF CLERK | | 239. SIGNATURE OF SHERIFF | | 240. SIGNATURE OF DEPUTY SHERIFF | |
| 241. SIGNATURE OF CONSTABLE | | 242. SIGNATURE OF JURY | | 243. SIGNATURE OF GRAND JURY | |
| 244. SIGNATURE OF COURT | | 245. SIGNATURE OF JUDGE | | 246. SIGNATURE OF CLERK | |
| 247. SIGNATURE OF SHERIFF | | 248. SIGNATURE OF DEPUTY SHERIFF | | 249. SIGNATURE OF CONSTABLE | |
| 250. SIGNATURE OF JURY | | 251. SIGNATURE OF GRAND JURY | | 252. SIGNATURE OF COURT | |
| 253. SIGNATURE OF JUDGE | | 254. SIGNATURE OF CLERK | | 255. SIGNATURE OF SHERIFF | |
| 256. SIGNATURE OF DEPUTY SHERIFF | | 257. SIGNATURE OF CONSTABLE | | 258. SIGNATURE OF JURY | |
| 259. SIGNATURE OF GRAND JURY | | 260. SIGNATURE OF COURT | | 261. SIGNATURE OF JUDGE | |
| 262. SIGNATURE OF CLERK | | 263. SIGNATURE OF SHERIFF | | 264. SIGNATURE OF DEPUTY SHERIFF | |
| 265. SIGNATURE OF CONSTABLE | | 266. SIGNATURE OF JURY | | 267. SIGNATURE OF GRAND JURY | |
| 268. SIGNATURE OF COURT | | 269. SIGNATURE OF JUDGE | | 270. SIGNATURE OF CLERK | |
| 271. SIGNATURE OF SHERIFF | | 272. SIGNATURE OF DEPUTY SHERIFF | | 273. SIGNATURE OF CONSTABLE | |
| 274. SIGNATURE OF JURY | | 275. SIGNATURE OF GRAND JURY | | 276. SIGNATURE OF COURT | |
| 277. SIGNATURE OF JUDGE | | 278. SIGNATURE OF CLERK | | 279. SIGNATURE OF SHERIFF | |
| 280. SIGNATURE OF DEPUTY SHERIFF | | 281. SIGNATURE OF CONSTABLE | | 282. SIGNATURE OF JURY | |
| 283. SIGNATURE OF GRAND JURY | | 284. SIGNATURE OF COURT | | 285. SIGNATURE OF JUDGE | |
| 286. SIGNATURE OF CLERK | | 287. SIGNATURE OF SHERIFF | | 288. SIGNATURE OF DEPUTY SHERIFF | |
| 289. SIGNATURE OF CONSTABLE | | 290. SIGNATURE OF JURY | | 291. SIGNATURE OF GRAND JURY | |
| 292. SIGNATURE OF COURT | | 293. SIGNATURE OF JUDGE | | 294. SIGNATURE OF CLERK | |
| 295. SIGNATURE OF SHERIFF | | 296. SIGNATURE OF DEPUTY SHERIFF | | 297. SIGNATURE OF CONSTABLE | |
| 298. SIGNATURE OF JURY | | 299. SIGNATURE OF GRAND JURY | | 300. SIGNATURE OF COURT | |

LAIRY BOD

CERTIFICATE OF DEATH

Reg. Dist. No.

10274

10285

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> 07X-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u> | | | | d. STREET ADDRESS <u>Charles Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CORDELIA MAE HORNBERGER</u> | | | | 4. DATE OF DEATH Month Day Year <u>SEPTEMBER 7 1959</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/24/98</u> | |
| 9. AGE (In years lost birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>THOMAS CHAMBERLAIN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annabelle Campbell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>J. Walter Hornberger</u> | | | | Address <u>Perryville, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> 260X DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular thrombosis</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>July 19th, 1959</u> to <u>Sept. 7th, 1959</u> , that I last saw the deceased alive on <u>Sept. 7th, 1959</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Perryville, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> | | | | DATE SIGNED <u>9/7/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-10-1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe C. Patterson & Son</u> | | | | ADDRESS <u>Perryville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>SEP 11 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10287

CERTIFICATE OF DEATH

10275

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE | | | | c. LENGTH OF STAY IN 1b 27 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ALICE Middle IOLA Last LAYE | | | | 4. DATE OF DEATH Month SEPTEMBER Day 24 Year 1959 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 30, 1896 | |
| 9. AGE (In years last birthday) 62 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) MARYLAND/Harford Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert WALLACE | | | | 14. MOTHER'S MAIDEN NAME FRANCES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give year or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 216-24-3476 | | | |
| 17. INFORMANT John Robert Laye | | | | Address 608 South Union Ave., Harford Co., Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of Splanic Flare with Metastasis 153.1 DUE TO to liver & lungs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:35 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Frank D. Hauser | | | | ADDRESS (Street, city or town, state) 608 South Union Ave., Harford Co., Md. | | | |
| DATE SIGNED _____ | | | | DATE SIGNED _____ | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Sept 27, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Dublin M. Cem Harford Co., Md. | | 22d. LOCATION (City, town, or county) (State) Harford Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. & Bailey | | | | ADDRESS Washington, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 29 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10309

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Norrisville | | c. LENGTH OF STAY IN 1b 4 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Norrisville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LAURA STANDIFORD LEMMON | | | | 4. DATE OF DEATH Month Day Year Sept. 28 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 1881 | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Nursing | | 11. BIRTHPLACE (State or foreign country) Monkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Standiford | | | | 14. MOTHER'S MAIDEN NAME Pierce | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-32-3147 | | INFORMANT Address Charles Lemmon Fallston, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arterial thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis generalizd. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days. 15 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 9-26 , 19 59 , to 9-28 , 19 59 , that I last saw the deceased alive on 9-26 , 19 59 , and that death occurred at 3 p.m. from the causes and on the date stated above. | | | | | | | DATE SIGNED |
| ACTUAL SIGNATURE William O. Fulton | | M.D. Stewart's town, Pa. | | | | | |
| PHYSICIAN'S NAME (Type) William O. Fulton | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/1/1959 | 22c. NAME OF CEMETERY OR CREMATORY Bethel | | 22d. LOCATION (City, town, or county) (State) Madonna Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Rudy | | | | ADDRESS Jarrettsville, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 2 '59 | 24b. REGISTRAR'S SIGNATURE Charles E. Rudy |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #2 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First IDA Middle COALE Last McVEY | | | | 4. DATE OF DEATH Month September Day 26 Year 19 59 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1876 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Philip F. Coale PHILIP F. COALE | | | | 14. MOTHER'S MAIDEN NAME Ella L. Loflin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ** ** | | 17. INFORMANT Mrs. Robert Payne, R.D. #2, Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis - arterial - 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Schistocytosis DUE TO (c) Heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 3/18 , 19 50 , to Sept 26, 1959 , that I lost sown the deceased alive on 9-26 , 19 59 , and that death occurred at 5:40AM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A.L. Lewis, M.D. | | | ADDRESS (Street, city or town, state) 214 N. Union Ave. | | | DATE SIGNED 9/26/59 | |
| PHYSICIAN'S NAME (Type) A.L. Lewis, M.D. | | | Hayre de Grace, Md. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/28/59 | | 22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring | | | | ADDRESS Tarring Funeral Home, Aberdeen, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 29 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur E. Evans | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10310

| | | | |
|---|--|--|--|
| <p>NAME OF DECEASED [Illegible Name]</p> | | <p>DATE OF DEATH [Illegible Date]</p> | |
| <p>RESIDENCE [Illegible Address]</p> | | <p>PLACE OF DEATH [Illegible Location]</p> | |
| <p>AGE [Illegible Age]</p> | | <p>SEX [Illegible Sex]</p> | |
| <p>DATE OF BIRTH [Illegible Date]</p> | | <p>PLACE OF BIRTH [Illegible Location]</p> | |
| <p>CAUSE OF DEATH [Illegible Cause]</p> | | <p>IMMEDIATE CAUSE [Illegible Cause]</p> | |
| <p>INTERVIEWED BY [Illegible Name]</p> | | <p>DATE OF INTERVIEW [Illegible Date]</p> | |
| <p>SIGNATURE OF DECEASED [Illegible Signature]</p> | | <p>SIGNATURE OF WITNESS [Illegible Signature]</p> | |
| <p>DATE OF SIGNATURE [Illegible Date]</p> | | <p>DATE OF SIGNATURE [Illegible Date]</p> | |



Vertical text on the right margin, likely containing filing or administrative information, mostly illegible due to orientation and fading.

10288

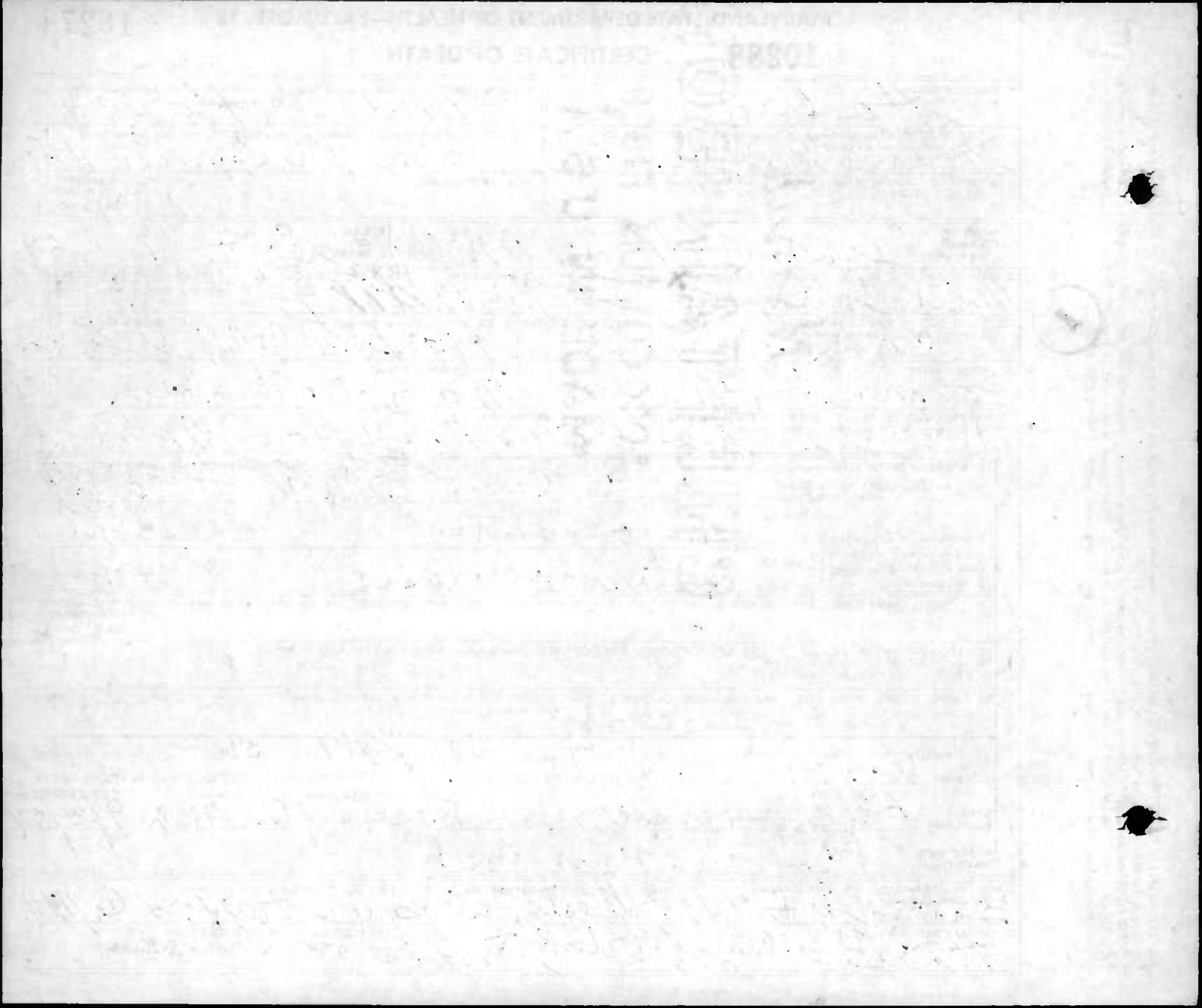
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lawrence Grace Rd</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lawrence Grace Rd</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Harry Miller</u> | | 4. DATE OF DEATH <u>Sept. 1 1959</u> | |
| 5. SEX <u>Male</u> <u>White</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 22 1902</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md, U.S.A</u> | 11. BIRTHPLACE (State or foreign country) |
| 13. FATHER'S NAME <u>James H. Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Baker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-26-5108</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> <u>422.1</u> DUE TO <u>myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> (c) <u>4 yr</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1958</u> to <u>Sept 1 1959</u> , that I last saw the deceased alive on <u>Aug 31 1959</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>P. F. Syrodgeass</u> M.D. | | ADDRESS (Street, city or town, state) <u>Barlingon Md</u> DATE SIGNED <u>9/3/59</u> | |
| PHYSICIAN'S NAME (Type) <u>P. F. Syrodgeass</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>4/19/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Reshyan Chapel</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u> | | 24. REC'D BY REGISTRAR <u>SEP 9 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur & Thomas</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10279

Reg. Dist. No.

10289

| | | | | | | | |
|--|------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> | | | | c. LENGTH OF STAY IN 1b <u>07X-2</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Colona</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Cleveland</u> Last <u>Mills</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1959</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 23 1886</u> | 9. AGE (In years last birthday) <u>73</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Taylor Mills</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jane Mills</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Maltida Mills, Colona Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 SW L. Chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9-25</u> o. m. <u>59</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Colona Cecil Md</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Lorrell C Palmer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Aci, Md</u> DATE SIGNED <u>9-28-59</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerold C Palmer, Md</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/30/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Darlington Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun Md</u> | | | | 24a. REC'D BY REGISTRAR <u>SEP 30 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanks</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED <i>John J. Smith</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>45</i> | | 4. OCCUPATION <i>Engineer</i> | |
| 5. PLACE OF BIRTH <i>Boston, Mass.</i> | | 6. DATE OF BIRTH <i>Jan 15, 1880</i> | |
| 7. PLACE OF DEATH <i>Home</i> | | 8. DATE OF DEATH <i>Jan 20, 1925</i> | |
| 9. TIME OF DEATH <i>10:30 AM</i> | | 10. CAUSE OF DEATH <i>Myocardial Infarction</i> | |
| 11. MANNER OF DEATH <i>Natural</i> | | 12. SIGNATURE OF EXAMINER <i>Dr. J. H. Jones</i> | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN <i>Dr. A. B. Brown</i> | | 14. SIGNATURE OF NEXT OF KIN <i>Mr. J. J. Smith</i> | |
| 15. SIGNATURE OF BURIAL OFFICIAL <i>Rev. W. D. Green</i> | | 16. SIGNATURE OF CLERK <i>Miss E. F. White</i> | |
| 17. SIGNATURE OF JURY <i>None</i> | | 18. SIGNATURE OF JUDGE <i>None</i> | |
| 19. SIGNATURE OF DISTRICT ATTORNEY <i>None</i> | | 20. SIGNATURE OF SHERIFF <i>None</i> | |
| 21. SIGNATURE OF CORONER <i>None</i> | | 22. SIGNATURE OF JAILER <i>None</i> | |
| 23. SIGNATURE OF PRISON WARDEN <i>None</i> | | 24. SIGNATURE OF CHIEF OF POLICE <i>None</i> | |
| 25. SIGNATURE OF DEPUTY CHIEF OF POLICE <i>None</i> | | 26. SIGNATURE OF INSPECTOR OF PRISON <i>None</i> | |
| 27. SIGNATURE OF INSPECTOR OF JAIL <i>None</i> | | 28. SIGNATURE OF INSPECTOR OF HOUSE OF CORRECTIONS <i>None</i> | |
| 29. SIGNATURE OF INSPECTOR OF STATE HOUSE <i>None</i> | | 30. SIGNATURE OF INSPECTOR OF STATE BUILDINGS <i>None</i> | |
| 31. SIGNATURE OF INSPECTOR OF STATE LANDS <i>None</i> | | 32. SIGNATURE OF INSPECTOR OF STATE TREASURY <i>None</i> | |
| 33. SIGNATURE OF INSPECTOR OF STATE EDUCATION <i>None</i> | | 34. SIGNATURE OF INSPECTOR OF STATE AGRICULTURE <i>None</i> | |
| 35. SIGNATURE OF INSPECTOR OF STATE MILITARY <i>None</i> | | 36. SIGNATURE OF INSPECTOR OF STATE NAVAL <i>None</i> | |
| 37. SIGNATURE OF INSPECTOR OF STATE AIR FORCE <i>None</i> | | 38. SIGNATURE OF INSPECTOR OF STATE SPACE <i>None</i> | |
| 39. SIGNATURE OF INSPECTOR OF STATE COMMERCE <i>None</i> | | 40. SIGNATURE OF INSPECTOR OF STATE TRANSPORTATION <i>None</i> | |
| 41. SIGNATURE OF INSPECTOR OF STATE LABOR <i>None</i> | | 42. SIGNATURE OF INSPECTOR OF STATE INDUSTRY <i>None</i> | |
| 43. SIGNATURE OF INSPECTOR OF STATE MINING <i>None</i> | | 44. SIGNATURE OF INSPECTOR OF STATE FORESTRY <i>None</i> | |
| 45. SIGNATURE OF INSPECTOR OF STATE FISH AND WILDLIFE <i>None</i> | | 46. SIGNATURE OF INSPECTOR OF STATE PARKS <i>None</i> | |
| 47. SIGNATURE OF INSPECTOR OF STATE RECREATION <i>None</i> | | 48. SIGNATURE OF INSPECTOR OF STATE HISTORICAL MONUMENTS <i>None</i> | |
| 49. SIGNATURE OF INSPECTOR OF STATE ARCHITECTURE <i>None</i> | | 50. SIGNATURE OF INSPECTOR OF STATE ENGINEERING <i>None</i> | |
| 51. SIGNATURE OF INSPECTOR OF STATE MECHANICAL <i>None</i> | | 52. SIGNATURE OF INSPECTOR OF STATE ELECTRICAL <i>None</i> | |
| 53. SIGNATURE OF INSPECTOR OF STATE CHEMICAL <i>None</i> | | 54. SIGNATURE OF INSPECTOR OF STATE PHYSICAL <i>None</i> | |
| 55. SIGNATURE OF INSPECTOR OF STATE METEOROLOGICAL <i>None</i> | | 56. SIGNATURE OF INSPECTOR OF STATE AERONAUTICAL <i>None</i> | |
| 57. SIGNATURE OF INSPECTOR OF STATE OPTICAL <i>None</i> | | 58. SIGNATURE OF INSPECTOR OF STATE ACOUSTICAL <i>None</i> | |
| 59. SIGNATURE OF INSPECTOR OF STATE THERMAL <i>None</i> | | 60. SIGNATURE OF INSPECTOR OF STATE MAGNETICAL <i>None</i> | |
| 61. SIGNATURE OF INSPECTOR OF STATE RADIOLOGICAL <i>None</i> | | 62. SIGNATURE OF INSPECTOR OF STATE NUCLEAR <i>None</i> | |
| 63. SIGNATURE OF INSPECTOR OF STATE COSMICAL <i>None</i> | | 64. SIGNATURE OF INSPECTOR OF STATE ASTROLOGICAL <i>None</i> | |
| 65. SIGNATURE OF INSPECTOR OF STATE GEMOLOGICAL <i>None</i> | | 66. SIGNATURE OF INSPECTOR OF STATE MINERALOGICAL <i>None</i> | |
| 67. SIGNATURE OF INSPECTOR OF STATE BOTANICAL <i>None</i> | | 68. SIGNATURE OF INSPECTOR OF STATE ZOOLOGICAL <i>None</i> | |
| 69. SIGNATURE OF INSPECTOR OF STATE ANTHROPOLOGICAL <i>None</i> | | 70. SIGNATURE OF INSPECTOR OF STATE LINGUISTICAL <i>None</i> | |
| 71. SIGNATURE OF INSPECTOR OF STATE PHILOLOGICAL <i>None</i> | | 72. SIGNATURE OF INSPECTOR OF STATE LITERARY <i>None</i> | |
| 73. SIGNATURE OF INSPECTOR OF STATE HISTORICAL <i>None</i> | | 74. SIGNATURE OF INSPECTOR OF STATE GEOGRAPHICAL <i>None</i> | |
| 75. SIGNATURE OF INSPECTOR OF STATE TOPOGRAPHICAL <i>None</i> | | 76. SIGNATURE OF INSPECTOR OF STATE CLIMATOLOGICAL <i>None</i> | |
| 77. SIGNATURE OF INSPECTOR OF STATE METEOROLOGICAL <i>None</i> | | 78. SIGNATURE OF INSPECTOR OF STATE AERONAUTICAL <i>None</i> | |
| 79. SIGNATURE OF INSPECTOR OF STATE OPTICAL <i>None</i> | | 80. SIGNATURE OF INSPECTOR OF STATE ACOUSTICAL <i>None</i> | |
| 81. SIGNATURE OF INSPECTOR OF STATE THERMAL <i>None</i> | | 82. SIGNATURE OF INSPECTOR OF STATE MAGNETICAL <i>None</i> | |
| 83. SIGNATURE OF INSPECTOR OF STATE RADIOLOGICAL <i>None</i> | | 84. SIGNATURE OF INSPECTOR OF STATE NUCLEAR <i>None</i> | |
| 85. SIGNATURE OF INSPECTOR OF STATE COSMICAL <i>None</i> | | 86. SIGNATURE OF INSPECTOR OF STATE ASTROLOGICAL <i>None</i> | |
| 87. SIGNATURE OF INSPECTOR OF STATE GEMOLOGICAL <i>None</i> | | 88. SIGNATURE OF INSPECTOR OF STATE MINERALOGICAL <i>None</i> | |
| 89. SIGNATURE OF INSPECTOR OF STATE BOTANICAL <i>None</i> | | 90. SIGNATURE OF INSPECTOR OF STATE ZOOLOGICAL <i>None</i> | |
| 91. SIGNATURE OF INSPECTOR OF STATE ANTHROPOLOGICAL <i>None</i> | | 92. SIGNATURE OF INSPECTOR OF STATE LINGUISTICAL <i>None</i> | |
| 93. SIGNATURE OF INSPECTOR OF STATE PHILOLOGICAL <i>None</i> | | 94. SIGNATURE OF INSPECTOR OF STATE LITERARY <i>None</i> | |
| 95. SIGNATURE OF INSPECTOR OF STATE HISTORICAL <i>None</i> | | 96. SIGNATURE OF INSPECTOR OF STATE GEOGRAPHICAL <i>None</i> | |
| 97. SIGNATURE OF INSPECTOR OF STATE TOPOGRAPHICAL <i>None</i> | | 98. SIGNATURE OF INSPECTOR OF STATE CLIMATOLOGICAL <i>None</i> | |
| 99. SIGNATURE OF INSPECTOR OF STATE METEOROLOGICAL <i>None</i> | | 100. SIGNATURE OF INSPECTOR OF STATE AERONAUTICAL <i>None</i> | |

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10280

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> 10290 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hannedo Grace</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Bel Air</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | | d. STREET ADDRESS <u>18112</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Betty Jean</u> Middle <u>Morrison</u> Last <u></u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 24 - 1942</u> | | 9. AGE (In years last birthday) <u>16</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Boone, NC</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Odin J. Wilcox</u> | | | 14. MOTHER'S MAIDEN NAME <u>Fay Stevens Bel Air, Md</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT Address <u>Mrs. Fay Nelson Bel Air Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>825X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture R Tibia, compound</u> DUE TO <u></u> (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 days</u> INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> am. <u>9-6</u> 19 <u>59</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 22</u> | | | |
| 20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u> | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Lorald C Palmer</u> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>9-10-59</u> | | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 13/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Memorial</u> | | | |
| 22d. LOCATION (City, town, or county) (State) <u>Fennoir</u> <u>N.C.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Archer, Bensons Md</u> | | | 24a. REC'D BY REGISTRAR <u>SEP 14 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneas</u> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--------------------------------------|--|-------------------------------|--|----------------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF DEATH | |
| 6. PLACE OF DEATH | | 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | | 10. SIGNATURE OF EXAMINER | |
| 11. SIGNATURE OF ATTENDING PHYSICIAN | | 12. SIGNATURE OF CORONER | | 13. SIGNATURE OF JURY | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF FUNERAL HOME | | 17. SIGNATURE OF BURIAL PLACE | | 18. SIGNATURE OF INTERMENT | | 19. SIGNATURE OF CREMATION | | 20. SIGNATURE OF OTHER | |
| 21. SIGNATURE OF OTHER | | 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | | 25. SIGNATURE OF OTHER | |
| 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | | 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | |
| 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | | 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | |
| 36. SIGNATURE OF OTHER | | 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | | 40. SIGNATURE OF OTHER | |
| 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | | 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | |
| 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | | 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | |
| 51. SIGNATURE OF OTHER | | 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | | 55. SIGNATURE OF OTHER | |
| 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | | 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | |
| 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | | 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | |
| 66. SIGNATURE OF OTHER | | 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | | 70. SIGNATURE OF OTHER | |
| 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | | 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | |
| 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | | 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | |
| 81. SIGNATURE OF OTHER | | 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | | 85. SIGNATURE OF OTHER | |
| 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | | 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | |
| 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | | 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | |
| 96. SIGNATURE OF OTHER | | 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | | 100. SIGNATURE OF OTHER | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10281

Reg. Dist. No.

| | | | |
|---|--|--|--|
| <p style="font-size: 1.2em; margin: 0;">10291</p> <p>1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND</p> | | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u></p> | |
| <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u></p> | | <p>c. LENGTH OF STAY IN 1b <u>31 1/2</u></p> | |
| <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u></p> | | <p>d. STREET ADDRESS <u>1736 W. H. St</u></p> | |
| <p>3. NAME OF DECEASED (Type or print) <u>(Gerald) Daniel Parrota</u></p> | | <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1959</u></p> | | <p>5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u></p> | |
| <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH <u>Aug 7th 1883</u></p> | |
| <p>9. AGE (In years last birthday) <u>76</u> yrs.</p> | | <p>IF UNDER 1 YEAR Months <u> </u> Days <u> </u></p> | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Retired</u></p> | | <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u></p> | |
| <p>11. BIRTHPLACE (State or foreign country) <u>Italy</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | |
| <p>13. FATHER'S NAME <u>Pasquale Parrota</u></p> | | <p>14. MOTHER'S MAIDEN NAME <u>Unknown</u></p> | |
| <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p> | | <p>16. SOCIAL SECURITY NO. <u>—</u></p> | |
| <p>17. INFORMANT <u>Tony P. Parrota</u></p> | | <p>Address <u>507 H West St</u></p> | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest during operation for</u> <u>584X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stone in Common Bile Duct</u> (c) <u>Cirrhosis liver</u></p> | | | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | |
| <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u></p> | | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> | |
| <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) (County) (State)</p> | |
| <p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> | | | |
| <p>ACTUAL SIGNATURE <u>Gerald C Palmer</u></p> | | <p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u></p> | |
| <p>EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u></p> | | <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> | |
| <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> | | <p>DATE SIGNED <u>9-15-59</u></p> | |
| <p>22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Memorial</u></p> | | <p>22b. DATE THEREOF <u>9/16/59</u></p> | |
| <p>22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u></p> | | <p>22d. LOCATION (City, town, or county) (State) <u>Corrsville, P. M.</u></p> | |
| <p>23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Darring</u></p> | | <p>ADDRESS <u>Bel Air, Maryland</u></p> | |
| <p>24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u></p> | | <p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u></p> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10-21
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | |
| AGE [Faint text, possibly "45"] | | RACE [Faint text, possibly "White"] | |
| DATE OF DEATH [Faint text, possibly "10-21-1918"] | | PLACE OF DEATH [Faint text, possibly "Home"] | |
| TIME OF DEATH [Faint text, possibly "10:00 AM"] | | PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"] | |
| CAUSE OF DEATH [Faint text, possibly "Pneumonia"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | |
| SIGNATURE OF EXAMINER [Faint signature] | | SIGNATURE OF DECEASED [Faint signature] | |
| CERTIFICATE OF DEATH [Faint text] | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text] | |



10-21-1918

10292

CERTIFICATE OF DEATH

10282

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVEY DE GRAVE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RISING SUN 07X-2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SAUL POWERS</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 22 1959</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>2/9/12</u> | 9. AGE (In years lost birthday) <u>47</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u> | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>ARTHUR POWERS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>OLIVE MCCLURE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated esophageal ulcer</u> DUE TO (b) <u>Cirrhosis of liver</u> (c) <u>Coronary Thrombosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs.</u> <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/18</u> , 19 <u>59</u> , to <u>9/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>59</u> , and that death occurred at <u>3:15</u> P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Neil Taylor</u> | | | | ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Neil Taylor</u> | | | | DATE SIGNED <u>9/23/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/25/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMETARY</u> | | 22d. LOCATION (City, town, or county) (State) <u>OXFORD PA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u> | | | | ADDRESS <u>Rising Sun, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10283

10293

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | c. LENGTH OF STAY IN 1b 3 yrs 9 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Oakington Road RR #22 | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Oakington Road RR #22 | | d. STREET ADDRESS 202 Parke Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ROGER Middle LAWRENCE Last RIDINGS | | 4. DATE OF DEATH Month September Day 30 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 15, 1936 |
| 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY US Army | 11. BIRTHPLACE (State or foreign country) Georgia |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Millard P Ridings | | 14. MOTHER'S MAIDEN NAME Unknown (deceased) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 257-50-0313 | |
| 17. INFORMANT Official Army Records | | Address Aberdeen Proving Ground, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (carbon monoxide) 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) carbon monoxide poisoning caused by hose extending from exhaust pipe to inside of car | | INTERVAL BETWEEN ONSET AND DEATH undetermined | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) carbon monoxide poisoning caused by hose extending from exhaust pipe to inside of car | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. unknown 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm | 20f. (City or town) (County) (State) Aberdeen Harford Maryland |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA , 19____, and that death occurred at 4:41 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED 30 Sep 59 | | | |
| ACTUAL SIGNATURE JAMES G ZANGRILLI | | M.D. US Army Hospital | |
| PHYSICIAN'S NAME (Type) JAMES G ZANGRILLI Capt MC | | Aberdeen Proving Ground, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF 10-2-59 | 22c. NAME OF CEMETERY OR CREMATORY Nat. Cemetery, Marietta, | 22d. LOCATION (City, town, or county) (State) Georgia. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14 | | 24a. REC'D BY REGISTRAR OCT 5 2 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kram | | | |

10294

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Silveretta</u> Middle <u>R.</u> Last <u>Schaub</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 1, 1903</u> | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u> | | IF UNDER 24 HRS. Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>George S. Schaub</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosa Datchatis</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>216-05-3265</u> | | 17. INFORMANT <u>Raymond Hooker, Abingdon, Maryland.</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>Sept 11, 1959</u> , that I last saw the deceased alive on <u>Sept 9, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>9-11-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u> | | | | Bel Air, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 14, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. McHenry</u> ADDRESS <u>Abingdon, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10285

10295

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Hartford</u> | | MARYLAND | | STATE <u>Mo</u> | | COUNTY <u>Hartford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BAL AIR Mo</u> | | LENGTH OF STAY (in this place) <u>54 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BAL AIR</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>318 N. MAIN ST.</u> | | | | STREET ADDRESS (If rural give location) <u>1 318 N MAIN ST</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>M ELLA SHAW</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 3 1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Sept 1 - 1867</u> | | 9. AGE last birthday <u>92</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Refired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Delta Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Geo T Butler</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY A THOMPSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> | | 16. SOCIAL SECURITY NO. <u>✓</u> | | 17. INFORMANT & ADDRESS <u>MRS JANE G COLE</u> <u>318 N MAIN ST BAL AIR Mo</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331x IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u> | | | | | | <u>24 HOURS</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u> | | | | | | <u>4 WEEKS</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1947</u> , to <u>1 SEPT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 SEPT</u> , 19 <u>59</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J H Audick</u> | | | | ADDRESS (Street, city, town, state) <u>4017 Washington Blvd</u> | | DATE SIGNED <u>Sept 5</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>Sept 5/59</u> | | NAME OF CEMETERY OR CREMATORY <u>Glata Ridge Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Delta Pa</u> | |
| 24. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u> | | REGISTRAR'S SIGNATURE <u>Curtis L. Kums</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> | | ADDRESS <u>Bel Air Md</u> | |

10296

CERTIFICATE OF DEATH

Reg. Dist. No.

10286

| | | | | | | | |
|--|--|--|--------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit - RURAL</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | | | d. STREET ADDRESS <u>07X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Frederick Smith</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 7 1959</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 4, 1906</u> | 9. AGE (In years last birthday) <u>52</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosina ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>ANNA SMITH, PORT DEPOSIT, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal obstruction - ? Peritonitis</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from <u>9-7</u> , 19 <u>57</u> , to <u>8-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>57</u> , and that death occurred at <u>12:15</u> P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Frank D. Hauke</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>608 South Union Ave., Haure de Grace, Md.</u> | | | |
| DATE SIGNED | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept. 9, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>State Ridge Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Delta Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Pa.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur & Klaus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 10287

10311

10287

Reg. Dist. No.

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

X 1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10288

Reg. Dist. No.

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harpur</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Bruce</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hanford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David Stine</u> | | 4. DATE OF DEATH <u>September 23</u> 19 <u>59</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 8 - 1927</u> |
| 9. AGE (In years last birthday) <u>31</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lineman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Coburn, Centre Co., Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Stine</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennie Ayman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Nov. 18/48 - Mar. 1949</u> | | 16. SOCIAL SECURITY NO. <u>184-20-0211</u> | |
| 17. INFORMANT <u>Mrs. Jennie Stine</u> | | Address <u>Coburn, Pa.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>910.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pole fell on his head</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> <u>23</u> <u>59</u> p. m. | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Forest Hill Harpur MD</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dennis C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-23-59</u> | |
| EXAMINER'S NAME (Type) <u>Gerard C Palmer</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/26/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Millheim Centre Co., Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Neff</u> | | ADDRESS <u>Millheim Pa.</u> | |
| 24a. REC'D BY REGISTRAR <u>SEP 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative notations.]

RECEIVED
STATE OF MARYLAND
HEALTH DEPT.
BALTIMORE, MARYLAND
JAN 15 1927

10298

CERTIFICATE OF DEATH

10289

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa</u> b. COUNTY <u>Lancaster</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural. Kerkwood. 75x-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Minnette</u> Middle <u>Belle</u> Last <u>Swisher</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1959</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 18. 1873</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at own home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Penna</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Simson W. Swisher</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Pennington</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>May S. Lewis</u> Address <u>201 W. Madison Baltimore</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/15</u> , 19 <u>59</u> , to <u>9/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/9</u> , 19 <u>59</u> , and that death occurred at <u>7⁴⁵</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Neil Taylor</u> M.D. | | ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>9/9/59</u> | |
| PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u> | | <u>Rising Sun, Md</u> <u>9/9/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Sept. 12. 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Pres. Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Kerkwood Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leet Patterson & Son</u> ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

| 11-3-59 AMS | | | | | | | | | |
|--|--|-------------------------------|---|--|--|---|--|---|--|
| Item 18 Film 251 | | | | | | | | | |
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 10299 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Harford | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 31 Aberdeen | | | | |
| c. LENGTH OF STAY IN 1b | | | | | d. STREET ADDRESS Level, Aberdeen, Md. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle LEE Last TAYLOR | | | | | 4. DATE OF DEATH Month September Day 18 Year 1959 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APR 16/57 | | 9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | | 11. BIRTHPLACE (State or foreign country) Harford Md | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Joseph L Taylor | | | | | 14. MOTHER'S MAIDEN NAME Dorothy Ackar | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) | | | | | 16. SOCIAL SECURITY NO. RD-2-Box 17A | | | | |
| 17. INFORMANT Joseph L Taylor Address Street Md | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple ulceration of skin and subcutaneous tissue. 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | DATE SIGNED 9/19/59 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 22b. DATE THEREOF Sept 21/59 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist | | 22d. LOCATION (City, town, or country) (State) Schuck's Corner Harford Md | | |
| 23. FUNERAL DIRECTOR Joseph J. L. Bel Air Md ADDRESS | | | | | 24a. REC'D BY REGISTRAR SEP 22 '59 DATE | | | | |
| | | | | | 24b. REGISTRAR'S SIGNATURE Arthur E. Kinner | | | | |

1

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, including references to New York and Washington, D.C.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

CERTIFICATE OF DEATH

10291

Reg. Dist. No.

| | | | | | | | | | | | | | | | |
|---|--|-------------------------------|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>Life-time</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>215 D. Washington</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodosia Kelly French</u> | | | | 4. DATE OF DEATH Month Day Year <u>9/14/59</u> 19 <u>59</u> | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OF RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/14/1871</u> | | 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Charles R. Kelly</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ella Emmons Miller</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | | 17. INFORMANT <u>Joseph H. Gibson</u> <u>215 S. Washington</u> <u>Harford</u> <u>Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> <u>254X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Large Cystic Thyroid</u> DUE TO (c) _____ | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>9/10/59</u> , 19 <u>59</u> , to <u>9/14/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10-39</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>A. L. Lewis M.D.</u> <u>254 N. Union Ave - Harford, Md</u> | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF <u>9/17/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hall</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Harford</u> <u>Md</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Harford</u> | | | | | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>SEP 18 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

CERTIFICATE OF DEATH

1919

Form No. 1

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. SMITH</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Age: <u>45</u></p> | | <p>4. Date of birth: <u>Jan 15, 1874</u></p> | |
| <p>5. Place of birth: <u>St. Louis, Mo.</u></p> | | <p>6. Date of death: <u>Dec 10, 1919</u></p> | |
| <p>7. Cause of death: <u>Heart disease</u></p> | | <p>8. Place of death: <u>Home</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of filing: <u>Dec 15, 1919</u></p> | | <p>12. File number: <u>100-100000</u></p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.

10301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12 Film 6249 9-24-59 et

Reg. Dist. No.

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Cecil</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hammonds Green</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i> 07X-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i> | | d. STREET ADDRESS <i>Mount St</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Sandra</i> Middle <i>Tressler</i> Last <i>Tressler</i> | | 4. DATE OF DEATH Month <i>September</i> Day <i>12</i> Year <i>1959</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 14, 1943</i> |
| 9. AGE (In years last birthday) <i>15</i> yrs. | | IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> | IF UNDER 24 HRS. Hours <i></i> Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Bethlehem, Penna.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>James Irwin Tressler</i> | | 14. MOTHER'S MAIDEN NAME <i>Isabelle Morgan</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Mrs Isabelle Tressler</i> | | Address <i>Rising Sun Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull, compound</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>816X</i> (c) <i></i> DUE TO (a) <i></i> (b) <i></i> (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident auto-auto type</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <i>5</i> p. m. <i>9-12-59</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>MD Route 222</i> | | 20f. (City or town) (County) (State) <i>Conowingo Cecil Md.</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Gerard C Palmer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>B. A. C. Md</i> DATE SIGNED <i>9-13-59</i> | |
| EXAMINER'S NAME (Type) <i>Gerard C Palmer M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9/16/1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Brookview</i> | | 22d. LOCATION (City, town, or county) (State) <i>Rising Sun Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed</i> | | ADDRESS <i>Rising Sun Md</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>SEP 15 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John W. Smith
2. Date of Death: 10/10/1910
3. Place of Death: Home
4. Age: 45 Years
5. Sex: Male
6. Race: White
7. Occupation: Teacher
8. Cause of Death: Heart Disease
9. Manner of Death: Natural
10. Signature of Examiner: [Signature]
11. Date of Certificate: 10/10/1910

RECORDED
INDEXED
OCT 11 1910
BALTIMORE, MD.

10302

CERTIFICATE OF DEATH

10294

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD HAVER DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X (Rural) Aberdeen</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ORVILLE</u> Middle <u>H.</u> Last <u>WALTER SR.</u> | | 4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>2</u> Year <u>1959</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 24, 1893</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>Albert Walter</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Annie Grimes</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>— — —</u> | | 17. INFORMANT Address <u>RD. #3,</u> <u>Mrs. Bessie Walter, Box 90, Aberdeen, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> <u>451X</u> DUE TO <u>with pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Slowly perforating abdominal</u> DUE TO <u>aortic aneurysm</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>5 days</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ o. m. _____ p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>59</u> , and that death occurred at <u>8:40</u> P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. H. Sadowsky</u> M.D. | | ADDRESS (Street, city or town, state) <u>504 LEWIS ST.</u> | |
| PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY MD</u> | | DATE SIGNED <u>9/2/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/6/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneas</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10303

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase Md.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase Md.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>725 D Washington</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Nettie Mahan</i> First Middle Last | | 4. DATE OF DEATH <i>9/17/59</i> Month Day Year | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/24/1893</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | 9. AGE (In years last birthday) <i>66</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Charles G. Mahan</i> | | 14. MOTHER'S MARDEN NAME <i>Sarah A. Tyson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>E.G. Walters</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Gall-bladder</i> 155.1 DUE TO <i>with liver metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>April 30th, 1959</i> to <i>9/17th, 1959</i> that I last saw the deceased alive on <i>9/17/59</i> , 19 <i>59</i> and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>211 N. Union Ave. Harold Chase, Md.</i> DATE SIGNED <i>9/19/59</i> | | | |
| ACTUAL SIGNATURE <i>Edward C. Foon, M.D.</i> | | PHYSICIAN'S NAME (Type) <i>Edward C. Foon, M.D. Harold Chase, Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <i>9/20/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i> | 22d. LOCATION (City, town, or county) (State) <i>Harold Chase, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. J. M. ...</i> | | 24a. REC'D BY REGISTRAR <i>SEP 22 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Charles E. ...</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

